

AUG 15 1941

Ion District No. 6441

Primary Registration District No. 4385

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Ozage  
(b) City or town Metz  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Marion Barnhart

3. (b) If veteran. Yes name war Pop 3. (c) Social Security No. 90

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
(b) Name of husband or wife Betty Jane Barnhart 6. (c) Age of husband or wife if alive 20 years  
7. Birth date of deceased July 18 1886 (Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Ozage County Mo (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Tom Barnhart

13. Birthplace 1 (City, town, or county) (State or foreign country)

14. Maiden name Jane (City, town, or county) (State or foreign country)

15. Birthplace 0 (City, town, or county) (State or foreign country)

16. (a) Informant Harmy Barnhart

(b) Address Metz, Mo.

17. (a) Burial (b) Date thereof Aug 2 1941 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stakes

18. (a) Signature of funeral director H. H. Stroup

(b) Address Metz, Mo.

19. (a) Aug 1 1941 (b) Robert Crater (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ozage  
(c) City or town Metz (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31<sup>st</sup> year 1941 hour 9:00 minute 30 P. M.

21. I hereby certify that I attended the deceased from one o'clock 3:15 P.M. 1941 to July the 31<sup>st</sup> 4:30 1941 that I last saw him alive on July the 31<sup>st</sup> 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris Duration

Due to Arterio Sclerosis

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature Henry C. Werner (M. D. or other) 0

Address Metz Mo Date signed 8-1-41

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*H H Strop*

Licensed Embalmer No.....

*2924*

P. O. Address.....

*meta mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25756  
Registrar's No. 16

Registration District No. 64

Primary Registration District No. 4385

1. PLACE OF DEATH:

(a) County Osage  
(b) City or town meta  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community all of life  
years, months or days

3. (a) PRINT FULL NAME William M. Barnhart

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Don Barnhart

13. Birthplace Memphis, Tenn. (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Janet West

15. Birthplace Marion Co. Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Osage  
(c) City or town meta  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

